FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041772

Facility Name: ASTA CARE CENTER OF ROCKFORD

Address: 707 W. RIVERSIDE BOULEVARD (Number) ROCKFORD (City) 61103 (Zip Code)

County: WINNEBAGO

Telephone Number: (847) 742-8822 **Fax #** (847) 742-9013

IDPA ID Number: 36-4080354

Date of Initial License for Current Owners: 06/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MICHAEL GILLMAN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,352	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,228	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,580	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	938	36	3,614	4,588	8
9	SNF/PED					9
10	ICF	30,352	1,765	703	32,820	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,290	1,801	4,317	37,408	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.62%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,593

Medicare Intermediary ADMINISTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,695	11,027	10,970	190,692		190,692		190,692			1
2	Food Purchase		152,778		152,778	(15,500)	137,278	(1,183)	136,095			2
3	Housekeeping	120,940	21,228		142,168		142,168		142,168			3
4	Laundry	29,845	7,823	2,685	40,353		40,353		40,353			4
5	Heat and Other Utilities			93,761	93,761		93,761		93,761			5
6	Maintenance	74,876	26,943	26,820	128,639		128,639	1,258	129,897			6
7	Other (specify):*			13,669	13,669		13,669		13,669			7
8	**TOTAL General Services**	394,356	219,799	147,905	762,060	(15,500)	746,560	75	746,635			8
	B. Health Care and Programs											
9	Medical Director			12,888	12,888		12,888		12,888			9
10	Nursing and Medical Records	1,453,518	98,653	18,539	1,570,710		1,570,710		1,570,710			10
10a	Therapy	68,308	594		68,902		68,902		68,902			10a
11	Activities	76,151	8,252	2,208	86,611		86,611		86,611			11
12	Social Services	33,509		1,920	35,429		35,429		35,429			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,631,486	107,499	35,555	1,774,540		1,774,540		1,774,540			16
	C. General Administration											
17	Administrative	78,013		162,000	240,013		240,013	(81,787)	158,226			17
18	Directors Fees											18
19	Professional Services			37,838	37,838		37,838	736	38,574			19
20	Dues, Fees, Subscriptions & Promotions			29,109	29,109		29,109	(9,420)	19,689			20
21	Clerical & General Office Expenses	116,117	20,155	28,970	165,242		165,242	19,051	184,293			21
22	Employee Benefits & Payroll Taxes			341,322	341,322	15,500	356,822		356,822			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,892	2,892		2,892		2,892			24
25	Other Admin. Staff Transportation			3,181	3,181		3,181	803	3,984			25
26	Insurance-Prop.Liab.Malpractice			117,665	117,665		117,665	2,345	120,010			26
27	Other (specify):*			18,456	18,456		18,456	(8,534)	9,922			27
28	**TOTAL General Administration**	194,130	20,155	741,433	955,718	15,500	971,218	(76,806)	894,412			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,219,972	347,453	924,893	3,492,318		3,492,318	(76,731)	3,415,587			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: ASTA CARE CENTER OF ROCKFORD #0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,560	
	REPAIRS & MAINTENANCE		3,005	
	OUTSIDE LABOR		405	10,970
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,685	
			0	2,685
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		38,080	
	ELECTRICITY		34,847	
	WATER		20,834	
	CABLE TV - LOBBY		0	
			0	93,761
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,800	
	PAINTING & DECORATING		53	
	BUILDING REPAIRS		1,191	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		20,274	
	ELEVATOR MAINTENANCE & REPAIR		2,338	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		164	
			0	
			0	
			0	26,820
7	**OTHER**			
	SCAVENGER		13,204	
	SECURITY SERVICE		465	13,669
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,888	12,888

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	1,920	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	366	
	PHARMACY CONSULTANT	XVIII B 39-2	1,417	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	1,100	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		1,248	
	PROGRAM CONSULTANT		12,488	18,539
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,208	
			0	2,208
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	960	
	SOCIAL WORKER	XVIII B 45-2	960	
			0	1,920
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD **#0041772** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	162,000	162,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,907	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	28,931	
			0	37,838
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,738	
	EMPLOYEE WANT ADS	XIX F	13	
	CONTRIBUTIONS	VI 20 XIX F	4,194	
	DUES & SUBSCRIPTIONS	XIX F	8,027	
	LICENSES & PERMITS	XIX F	10,009	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	881	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	247	29,109
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,714	
	EQUIPMENT REPAIR & MAINTENANCE		1,750	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,371	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,044	
	MESSENGER SERVICE		91	
			0	28,970

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	163,984	
	UNEMPLOYMENT COMPENSATION	XIX D	41,380	
	WORKERS COMPENSATION INSURANCI	XIX D	64,808	
	HOSPITALIZATION INSURANCE	XIX D	56,404	
	EMPLOYEE BENEFITS - OTHER	XIX D	12,769	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,977	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	341,322
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,892	
	TRAVEL	XIX G	0	
			0	
			0	2,892
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,181	3,181
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		117,665	117,665
27	**OTHER**			
	BAD DEBTS	VI 24	18,456	
				18,456

GRAND TOTAL COLUMN 3 OTHER 924,893

ASTA CARE CENTER OF ROCKFORD
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	152,778	PATIENT MEALS	112224
LESS SALES TAX	(1,066)	ADD EMPLOYEE MEALS	12810
NET FOOD	151,712	TOTAL MEALS/YEAR	125034
TOTAL PATIENT CENSUS	37,408	NET FOOD	151712
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	125034
TOTAL PATIENT MEALS	112224	COST PER MEAL	1.21
		TIME EMPLOYEE MEALS	12810
ADD # EMPLOYEE MEALS/DAY	35		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	15500
TOTAL EMPLOYEE MEALS	12810		

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD #0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			46,766	46,766		46,766	(3,690)	43,076			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,506	22,506		22,506	(1,301)	21,205			32
33	Real Estate Taxes			55,566	55,566		55,566		55,566			33
34	Rent-Facility & Grounds			603,619	603,619		603,619		603,619			34
35	Rent-Equipment & Vehicles			21,060	21,060		21,060	2,402	23,462			35
36	Other (specify):* **computer amort**			641	641		641		641			36
37	**TOTAL Ownership**			750,158	750,158		750,158	(2,589)	747,569			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,697	164,359	289,056		289,056		289,056			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,370	71,370		71,370		71,370			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		124,697	235,729	360,426		360,426		360,426			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,219,972	472,150	1,910,780	4,602,902		4,602,902	(79,320)	4,523,582			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,690)	30		9
10	Interest and Other Investment Income	(1,301)	32		10
11	Discounts, Allowances, Rebates & Refunds	(117)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,066)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,371)	21		18
19	Entertainment		20		19
20	Contributions	(4,194)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,469)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,456)	27		24
25	Fund Raising, Advertising and Promotional	(6,619)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(3,004)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,287)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(34,033)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (34,033)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (79,320)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ASTA CARE CENTER OF ROCKFORD

ID# 0041772

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1258	6	1
2	BANK CHARGES	(3,714)	21	2
3	MARKETING TRAVEL	(548)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,004)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,183)	0	0	0	0	0	0	0	0	0	0	(1,183)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,258	0	0	0	0	0	0	0	0	0	0	1,258	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	75	0	0	0	0	0	0	0	0	0	0	75	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(81,787)	0	0	0	0	0	0	0	0	0	(81,787)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,469)	3,205	0	0	0	0	0	0	0	0	0	736	19
20	Fees, Subscriptions & Promotions	(10,813)	1,393	0	0	0	0	0	0	0	0	0	(9,420)	20
21	Clerical & General Office Expenses	(8,085)	27,136	0	0	0	0	0	0	0	0	0	19,051	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(548)	1,351	0	0	0	0	0	0	0	0	0	803	25
26	Insurance-Prop.Liab.Malpractice	0	2,345	0	0	0	0	0	0	0	0	0	2,345	26
27	Other (specify):*	(18,456)	9,922	0	0	0	0	0	0	0	0	0	(8,534)	27
28	**TOTAL General Administration**	(40,371)	(36,435)	0	0	0	0	0	0	0	0	0	(76,806)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(40,296)	(36,435)	0	0	0	0	0	0	0	0	0	(76,731)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(3,690)	0	0	0	0	0	0	0	0	0	0	(3,690)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,301)	0	0	0	0	0	0	0	0	0	0	(1,301)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	2,402	0	0	0	0	0	0	0	0	0	2,402	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,991)	2,402	0	0	0	0	0	0	0	0	0	(2,589)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,287)	(34,033)	0	0	0	0	0	0	0	0	0	(79,320)	45

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED	LIST ATTACHED			ASTA HEALTHCARE		
				COMPANY	ELGIN	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 162,000	ASTA HEALTHCARE COMPANY		$	$ (162,000)	1
2	V	17	OFFICER'S SALARY				20,283	20,283	2
3	V	17	ADMINISTRATIVE SALARY				59,930	59,930	3
4	V	19	PROFESSIONAL FEES				3,205	3,205	4
5	V	20	SUBSCRIPTIONS				1,393	1,393	5
6	V	21	OFFICE EXPENSE				27,136	27,136	6
7	V	25	AUTO TRAVEL				1,351	1,351	7
8	V	26	INSURANCE GENERAL				2,345	2,345	8
9	V	27	PAYROLL TAX & EMPL BEN				9,922	9,922	9
10	V	35	EQUIPMENT RENTAL				2,402	2,402	10
11	V								11
12	V								12
13	V								13
14	Total			$ 162,000			$ 127,967	$ * (34,033)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5		SEE ATTACHED									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ASTA HEALTHCARE COMPANY
Street Address: 134 N MCLEAN BLVD
City / State / Zip Code: ELGIN, IL 60123
Phone Number: (847)742-8822
Fax Number: (847)742-9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER'S SALARY	PATIENT DAYS	177,049	6	$ 96,000	$ 96,000	37,408	$ 20,283	1
2	17	ADMINISTRATIVE SALARY	PATIENT DAYS	177,049	6	283,644	283,644	37,408	59,930	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	177,049	6	15,169		37,408	3,205	3
4	20	SUBSRIPTIONS	PATIENT DAYS	177,049	6	6,594		37,408	1,393	4
5	21	OFFICE EXPENSE	PATIENT DAYS	177,049	6	128,433	94,192	37,408	27,136	5
6	25	AUTO TRAVEL	PATIENT DAYS	177,049	6	6,394		37,408	1,351	6
7	26	INSURANCE GENERAL	PATIENT DAYS	177,049	6	11,101		37,408	2,345	7
8	27	PAYROLL TAX & EMPL BEN	PATIENT DAYS	177,049	6	46,962		37,408	9,922	8
9	35	EQUIPMENT RENTAL	PATIENT DAYS	177,049	6	11,370		37,408	2,402	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 605,667	$ 473,836		$ 127,967	25

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK ONE		X	LINE OF CREDIT	INTEREST	6/03/96	500,000	131,396	REVOLV	PRIME +	17,188	6
7	INSURANCE POLICIES		X	INSURANCE POLICIES							3,318	7
8	RELATED PARTIES	X									2,000	8
9	TOTAL Facility Related						$ 500,000	$ 131,396			$ 22,506	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 500,000	$ 131,396			$ 22,506	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 4,662	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 5,114	2
3. Under or (over) accrual (line 2 minus line 1).		$ 452	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 55,114	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 55,566	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	53,793	8
	2000	53,132	9
	2001	53,333	10
	2002	54,662	11
	2003	55,114	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF ROCKFORD COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041772

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-01-304-008	NURSING HOME	$ 55,113.70	$ 55,113.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,113.70	$ 55,113.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NURSES STATION			1997	15,290	392	39	392		2,760	9
10	FIRE PANEL			1997	1,691	43	39	43		303	10
11	ROOF			1997	4,035	104	39	104		732	11
12	TWO BATHROOMS			1998	4,615	118	39	118		782	12
13	COOLING TOWER			1998	7,552	194	39	194		1,188	13
14	PLUMBING - GREASE TRAP			1999	1,024	37	27.5	37		205	14
15	PLUMBING - NEW SINKS			1999	1,321	48	27.5	48		266	15
16	HOT WATER HEATER			1999	2,955	107	27.5	107		593	16
17	HEAT EXCHANGE			1999	2,298	84	27.5	84		465	17
18	NEW BATHROOMS			1999	9,975	363	27.5	363		2,011	18
19	NEW CEILING			1999	1,841	67	27.5	67		371	19
20	NURSE CALL SYSTEM			1999	8,437	307	27.5	307		1,701	20
21	NEW COOLING TOWER			1999	4,765	173	27.5	173		959	21
22	ROOF			2000	16,000	582	27.5	582		2,643	22
23	COUNTERYOP SINK			2000	2,275	83	27.5	83		377	23
24	TILING			2000	600	22	27.5	22		100	24
25	TOILETS			2000	7,702	280	27.5	280		1,272	25
26	CLOSETS, DRYWALL, TILING			2000	4,600	167	27.5	167		759	26
27	SHELVES			2000	1,250	45	27.5	45		205	27
28	DRAPES			2000	1,040	97	7	97		798	28
29	DRAPES			2000	10,639	1,068	7	1,068		7,959	29
30	VINYL FLOORING			2000	17,233	1,731	7	1,731		12,917	30
31	WALL COVERING			2001	2,696	311	5	311		2,244	31
32	FLOOR TILE & VINYL			2001	12,481	1,438	5	1,438		10,304	32
33	CUBICLE CURTAINS			2001	5,873	676	5	676		4,865	33
34	DOOR LOCKING SYSTEM			2001	2,960	108	27.5	108		382	34
35	DIALYSIS ROOM			2001	19,931	725	27.5	725		2,568	35
36	SEPTIC INJECTOR			2001	3,004	109	27.5	109		386	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ROOF	2001	$ 20,600	$ 749	27.5	$ 749	$	$ 2,653	37
38	SCREEN PORCH	2001	5,500	200	27.5	200		708	38
39	ELECTRONIC DOOR SCREEN FOR ELEVATOR	2001	6,887	250	27.5	250		886	39
40	BUILD WALLS, PAINTING, WOOD MOLDING	2001	5,700	207	27.5	207		733	40
41	FIRE ALARM SYSTEM	2002	12,867	468	27.5	468		1,189	41
42	CHAIR RAIL	2002	546	20	27.5	20		51	42
43	WATER HEATER	2002	2,229	81	27.5	81		206	43
44	GREASE TRAP	2002	1,050	38	27.5	38		97	44
45	SEWAGE EJECTOR PIT	2002	7,657	278	27.5	278		707	45
46	CODE ALERT WANDERING SYSTEM	2002	3,173	115	27.5	115		293	46
47	FLOORING, HANDRAILS, CORNER GUARD	2002	59,554	2,166	27.5	2,166		5,505	47
48	COVE BASE	2002	730	27	27.5	27		68	48
49	COVE BASE	2002	630	23	27.5	23		58	49
50	HANDRAILS, CORNER GUARDS	2002	7,947	289	27.5	289		735	50
51	WALLCOVERINGS	2002	3,578	481	5	481		2,832	51
52	PAINTING & WALLCOVERINGS	2002	6,572	883	5	883		5,235	52
53	WINDOW TREATMENTS	2002	3,722	500	5	500		2,884	53
54	WALLCOVERINGS, PAINTING	2002	19,304	2,595	5	2,595		15,335	54
55	WALLCOVERINGS	2002	2,277	306	5	306		1,923	55
56	WALLCOVERINGS, PAINTING	2002	12,600	1,693	5	1,693		10,051	56
57	WALLCOVERINGS	2002	2,277	306	5	306		1,923	57
58	GENERATOR	2003	40,000	1,455	27.5	1,455		2,243	58
59	FLOORING	2004	13,068	257	27.5	257		257	59
60	FIRE RATED CEILING TILE	2004	5,675	112	27.5	112		112	60
61	GREASE TRAP	2004	1,420	28	27.5	28		28	61
62	EXHAUST FAN	2004	867	17	27.5	17		17	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 420,513	$ 23,023		$ 23,023	$	$ 116,844	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 197,147	$ 19,691	$ 19,715	$ 24	10 YRS	$ 90,691	71
72	Current Year Purchases	6,753	4,052	338	(3,714)	10 YRS	338	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 203,900	$ 23,743	$ 20,053	$ (3,690)		$ 91,029	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 624,413	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 46,766	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,076	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,690)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 207,873	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: HOLT HEALTHCARE CENTRE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		135	06/01/96	$ 603,619	30		3
4	Additions							4
5								5
6								6
7	TOTAL		135		$ 603,619 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 06/01/96
Ending 06/01/26

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ 689,850
13.	/2006	$ 689,850
14.	/2007	$ 689,850

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 21,060 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 28,330	$		$ 28,330	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			15,615			15,615	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			105,518			105,518	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8				14,896	124,697		139,593	13
14	TOTAL			$		$ 164,359	$ 124,697		$ 289,056	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,998	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,196,587		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,565		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	539,204		8
9	Other(specify): RE escrow, emp. Loans	44,063		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,808,417	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	320,221		15
16	Equipment, at Historical Cost	308,627		16
17	Accumulated Depreciation (book methods)	(291,881)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 336,967	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,145,384	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 306,387	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	131,396		29
30	Accrued Salaries Payable	71,556		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,811		31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,114		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 575,264	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 575,264	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,570,120	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,145,384	$	48

*(See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,302,382	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,302,382	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	267,738	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 267,738	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,570,120	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,690,086	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,690,086	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,978	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 167,978	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,418	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,418	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ PRIOR YEAR EXPENSE	18,780	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,780	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,878,262	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	762,060	31
32	Health Care	1,774,540	32
33	General Administration	955,718	33
	B. Capital Expense		
34	Ownership	750,158	34
	C. Ancillary Expense		
35	Special Cost Centers	289,056	35
36	Provider Participation Fee	71,370	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,602,902	40
41	**Income before Income Taxes (line 30 minus line 40)****	275,360	41
42	**Income Taxes**	(7,622)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 267,738	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,565	2,869	$ 105,771	$ 36.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,513	14,083	342,461	24.32	3
4	Licensed Practical Nurses	15,973	17,254	366,134	21.22	4
5	Nurse Aides & Orderlies	54,494	57,961	600,732	10.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,623	1,691	41,105	24.31	7
8	Rehab/Therapy Aides	2,466	2,623	27,203	10.37	8
9	Activity Director	1,993	2,155	26,382	12.24	9
10	Activity Assistants	6,721	7,020	49,769	7.09	10
11	Social Service Workers	3,042	3,236	33,509	10.36	11
12	Dietician					12
13	Food Service Supervisor	3,090	3,408	38,789	11.38	13
14	Head Cook	4,290	4,779	53,857	11.27	14
15	Cook Helpers/Assistants	9,782	10,621	76,049	7.16	15
16	Dishwashers					16
17	Maintenance Workers	7,206	7,565	74,876	9.90	17
18	Housekeepers	14,703	15,996	120,940	7.56	18
19	Laundry	4,659	4,862	29,845	6.14	19
20	Administrator	1,961	2,163	78,013	36.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,166	8,736	116,117	13.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,701	2,890	38,420	13.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,948	169,912	$ 2,219,972 *	$ 13.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,560	1-3	35
36	Medical Director	O	12,888	9-3	36
37	Medical Records Consultant	N	366	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,417	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	2,208	11-3	44
45	Social Service Consultant	E	1,920	12-3	45
46	Other(specify) PROGRAM	E	12,488	10-3	46
47	PSYCHO SOCIAL	S	1,920	10-3	47
48	PSYCHIATRIC		1,100	10-3	48
49	TOTAL (lines 35 - 48)		$ 41,867		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY ZBINDEN	ADMIN	0	$ 78,013
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,013

B. Administrative - Other

Description	Amount
ASTA HEALTH CARE CO - MANAGEMENT FEES	$ 162,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 162,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		37,838
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 37,838

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 64,808
Unemployment Compensation Insurance		41,380
FICA Taxes		163,984
Employee Health Insurance		56,404
Employee Meals		15,500
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		12,769
EMPLOYEE PHYSICAL EXAMS		1,977
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 356,822

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13
Health Care Worker Background Check	247
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	6,619
TRUST/FRANCHISE/CONTRIB/ETC	4,194
LICENSES & PERMITS	10,009
DUES & SUBSCRIPTIONS	8,027
MGMT CO ALLOCATION	1,393
TRUST/FRANCHISE/CONTRIB/ETC	(4,194)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,619)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,689

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	2,892
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,892

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT / DECORATING	2000	$ 3,649	3 YR	$ 1,216	$ 1,216	$ 609	$	$	$	$	$	$
2	PAINT / DECORATING	2001	3,197	3 YR	534	1,065	1,065	533					
3	PAINT / DECORATING	2002	2,176	3 YR		363	725	725	363				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,022		$ 1,750	$ 2,644	$ 2,399	$ 1,258	$ 363	$	$	$	$

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Healthcare Assoc. $7696**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **71,370**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,500** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees